STOP SMOKING INTERVENTIONS IN PHARMACY
Service Specification 2023

1. INTRODUCTION
1.1 National/local context and evidence base

Smoking remains the single largest cause of preventable deaths and one of the largest causes of health inequalities in England. There are still 7.3 million adult smokers and more than 200 people a day die from smoking related illness which could have been prevented.

As well as dying prematurely, smokers also suffer many years in poor health. Many of the conditions caused by smoking are chronic illnesses which can be debilitating for the sufferer and make it difficult to carry out day to day tasks and engage with society and the economy. Smokers proportionately are less likely to be in work.

The impact of smoking in Plymouth
Tobacco use is the primary cause for health inequalities. (Wanless, 2004). The difference in life expectancy between the wards with the highest and lowest life expectancy values in Plymouth was 7.7 years for the period 2014-16, ("Life Expectancy in Plymouth", Office of the Director of Public Health, 2017).

The smoking attributable mortality rate per 100,000 people for Plymouth (2017-19) is 256

The smoking attributable hospital admission rate per 100,000 people for Plymouth (2019/20) is 1,622.

People who smoke:
- see their GP an average of 35% more than people who do not smoke.
- absent from work 2.7 days more per year compared to ex and non-smokers and smoking breaks result in lost output for employers.

These costs add a great burden to a system already dealing with growing demand.

Tobacco is estimated to cost Plymouth's economy in excess of £60 million per year and costs the NHS in Plymouth around £4m per year (ASH).

Smoking-related ill health also leads to increased costs for the adult social care system. The total additional spending on social care for Plymouth amounts to an estimated £8 million per year.

Table 1. Local Tobacco Control Profiles (OHID, accessed April 2023)

Smoking Prevalence in adults (18+) - current smokers 2021 *Source: Annual Population Survey (APS)*	
Plymouth	15.5%
England	13.0%

Therefore the provision of a high-quality local stop smoking services and effective local tobacco control interventions are a fundamental priority in reducing health inequalities and improving health among the communities of Plymouth.

This Service Specification directly contributes to reducing the smoking prevalence in adults, which is a Health Improvement indicator of the Public Health Outcomes Framework.

Therefore the provision of a high-quality local stop smoking services and effective local tobacco control interventions are a fundamental priority in reducing health inequalities and improving health among the communities of Plymouth. This PHS will provide clients with an additional option for accessing support to smoking cessation.

The more availability and greater options for clients the more likely it is to lead to an increase in uptake of smoking cessation support.

This Service Specification directly contributes to reducing the smoking prevalence in adults, which is a Health Improvement indicator of the Public Health Outcomes Framework.

2. PURPOSE

This service aims to support the reduction of smoking prevalence in Plymouth. It will enable clients to access high quality, evidenced based support to stop smoking in a way which best meets their needs based in the Pharmacy setting.

The PHS will also support the achievement of Health Improvement Smoking Cessation quitter targets as defined by Office of the Director for Public Health (ODPH) within PCC.

3. SERVICE DESCRIPTION

3.1 Key activity

The pathway shall include the following elements:

Brief Intervention (not monitored)

1. Smoker presents to a Pharmacy. Address with "how do you feel about your smoking?"

   In all cases offer support: "Did you know that the best way to quit is with free NHS support and medication? We actually provide the service here in the pharmacy. Would you like me to book you an appointment?"

2. If motivated to stop smoking then provide support in line with this specification.

Pharmacy Practitioner
(Registered with Plymouth Stop Smoking Service under the Pharmacy Public Health Contract)

3. The Pharmacy will arrange an initial appointment for each patient wishing to use the Community Pharmacy's stop smoking service to set a quit day (20-30 minute appointment).

4. Patients should be seen in-house. The Pharmacy shall provide a consultation room that offers suitable privacy and confidentiality to the client and use this when consulting the client for this service (unless the client does not wish to do so, or the pharmacist believes this would threaten his or her safety).

5. Assess motivation to quit.

6. Raise monitoring form on PharmOutcomes

7. Provide counselling and support. Assess medication options for quitting in line with South & West Devon Formulary and Referrals prescribing recommendations, (SWDFR) including suitability.

8. NRT can be recommended and issued by the pharmacy*. If necessary refer to patient's practice/ GP for a prescription. (See Appendix 3 for 'Medication Protocol for Pharmacy PHS').

9. Arrange a follow up appointment at 2 week stage before issuing further smoking cessation medications. (10-20 minute appointments).

10. Arrange follow up appointment at 4 week stage before issuing any further medications (10-20 minute appointments); complete PharmOutcomes form.

11. The Practitioner will CO validate with a smokerlyser at each consultation. All quits will be verified by a smokerlyser which will be provided free of charge to the Community Pharmacy by the Livewell South West WellBeing Team.

7. Where the quit is unsuccessful, clients may be seen again under this PHS. In these cases, the client's readiness to quit should be assessed prior to providing NRT and support (in line with the SWDFR).

If the practitioner loses contact with the client (DNA etc) then two attempts to contact the patient must be made via telephone to determine outcome of the quit attempt.

*All medications recommended and issued from the pharmacy should be:

- recorded on PharmOutcomes;
- issued in accordance with SWDFR prescribing recommendations;
- overseen by an appropriate Pharmacist for purposes of clinical responsibility.

Patients with specialist needs should be referred to the specialist arm of the LWSW Stop Smoking Service for intensive support (see appendix 1). Such patients include (but are not exclusive to): under 18s, pregnant women, highly dependent smokers, those with mental health needs or those with specific diseases such as CVD or COPD. Plymouth Livewell Southwest Stop Smoking Service is available for support and advice for all pharmacy based practitioners. Outcome letter should be forwarded to the person's surgery.

3.2 Eligibility criteria

Residents and visitors to Plymouth who would like support to stop smoking in the Pharmacy setting.

Appropriate Community Pharmacies eligible to provide this PHS will be selected based on location & demographic access.

In addition, Pharmacies must be able to demonstrate that they meet the following requirements, prior to initiation of this contract:

1. Staffing requirements – see section 4.3
2. IT – access and user knowledge of PharmOutcomes
3. Resources – ready access to a suitable consultation room, smokerylyser CO monitoring equipment and publicity material.

The Practitioner will refer to Livewell South West Well Being Team any smoker whom the Practitioner feels would benefit from more intensive specialist support that can be offered in the Community Pharmacy. This may include under 18's,

pregnant women, adolescents, those with specific diseases (e.g. COPD or CVD), smokers with mental health problems or learning difficulties and people who are heavily addicted to nicotine.
The Practitioner will apply any exclusion criteria as described by SWDFR. For information on clinically relevant medications that interact with smoking please see 'Which medicines need dose adjustment when a patient stops smoking?' (Appendix 5).

Patients should be assessed for suitability of recommended smoking cessation medications.

The advice of the Livewell Southwest Wellbeing Team may be sought by the Practitioner at any time.

3.3 Referral routes

This service is available to residents and visitors to Plymouth who would like support to stop smoking in the Pharmacy setting.

3.4 Access to the service

This PHS will be available within normal Pharmacy opening hours.

4. NETWORKS AND LINKS

This PHS will act as part of a coordinated city wide Stop Smoking Service and is therefore interdependent with the core smoking cessation 'specialist service' located within the LWSWWBT. The Specialist Service will:

1. Provide advice to the Community Pharmacy at any reasonable time
2. Provide training to act under this PHS
3. Provide each Pharmacy providing this PHS with a smokerlyser free of charge for use in delivering this Service
4. Be available (in the form of the LSWWBT see Appendix 1) to provide expert advice and support to Practitioners.
5. Provide feedback to the Pharmacy practice in relation to smoking cessation activity and the number of CO verified 4 week quitters.
6. Send quarterly outcome data of the individual's quit attempt to the LPC upon receiving qualifying monitoring data.

5. OTHER KEY TASKS

Ensure that the relevant Pharmacist takes clinical responsibility for all Nicotine Replacement Therapy (NRT) medications that are issued to clients on behalf of the relevant Pharmacy. For information on clinically relevant medications that interact with smoking please see 'Which medicines need dose adjustment when a patient stops smoking?' Appendix 5.

It is recommended that the responsible Pharmacist undertakes and completes the relevant CPPE Smoking Cessation Training (see 'Staff Training').

Advertise the availability of support to stop smoking within the Community Pharmacy (posters can be obtained from smokefree nhs website).

Use PharmOutcomes to monitor and register all smoking cessation PHS activity. All monitoring data, where possible, should be given consent by the patient (registered in PharmOutcomes) to enable LWSWWBT to follow up outcomes and service evaluation. The monitoring data should contain details of all NRT medications issued and be overseen by the relevant Pharmacist.

Ensure that all appropriate Community Pharmacy staff regularly refer smokers who are ready to quit to either their in-house stop smoking practitioner or to the specialist service as per the Smoking Cessation Guidelines (Appendix 2).

Accurately inform patients about NRT and other pharmacotherapies as recommended by the SWDFR, and recommend/issue medications as appropriate ensuring that the patient is offered choice of where to receive the help they need to quit smoking as identified in the Smoking Cessation Guidelines (Appendix 2). Follow up will be required and monitoring data registered on PharmOutcomes in all circumstances.

Make contact with patients 'lost to follow-up'. This will require a minimum of 2 telephone calls or other contacts to ascertain quit status.

Validate quit attempts with a CO reading. (CO readers will be issued and maintained by Livewell Southwest Wellbeing Team see 3.5).

Insurances

The pharmacy contractor and / or pharmacists are responsible for ensuring that professional indemnity insurance arrangements are in place for the operation of the enhanced service.

The pharmacy and accredited pharmacist must report any incidents, near-misses and complaints relating to this service according to their organisational policies and procedures and also communicate this to Plymouth City Council.

The advice of the Livewell Southwest Wellbeing Team may be sought by the Practice at any time.

6. STAFF

Staffing requirements

It is recommended that the responsible Pharmacist undertakes and completes the following CPPE Smoking Cessation Training:

- Stop Smoking NCSCT stage 1 and 2 assessment

This course is available online at - **http://www.cppe.ac.uk**

- At least one person per Community Pharmacy will attend a 1- day workshop (Community Practitioner Training for Pharmacies) run by the Livewell South West Well Being Team before providing services under this PHS. The training will be run to NCSCT required training standards.

Anyone who has attended training from other Stop Smoking Services or from the Maudsley Clinic would be able to practice providing they have continued to update their knowledge and skills through annual updates at the discretion of Livewell South West Well Being Team.

Practitioners are expected to attend at least one on-going training session annually to ensure they are kept up to date with new evidence and research.

7. SERVICE VOLUMES

Remuneration will be paid by the Commissioner to the Provider as follows, and in line with the payment process as specified in Annex 3:

Set quit date but not quit/ lost to follow up	£20.00
or	
Unverified quit	£50.00
or	
CO verified quit	£55.00

All NRT will be reimbursed at current drug tariff prices plus 5% for VAT less any prescription charges taken.

Other costs:
No additional remuneration is available for Practitioners' time spent training etc.
No additional remuneration is available for other Community Pharmacy staff members' time in relation to this PHS.

8. PERFORMANCE
8.1 Outcomes

Locally agreed outcomes and quality requirements

Outcome	Measure	Annual Target	Evidence Source	Reporting mechanism
Smoking Prevalence – Adult (over 18)	Number of CO verified 4 week quitters (%)	N/A	Monitoring Forms sent to Livewell Southwest Wellbeing Team (Appendix 1)	PharmOutcomes

9. QUALITY REQUIREMENTS

Applicable national standards

Tobacco: preventing uptake, promoting quitting and treating dependence NICE guideline [NG209] Published: 30 November 2021

Applicable local standards
It is the responsibility of the Pharmacist at each provider site to satisfactorily comply with his or her obligations under Schedule 1 of the Pharmaceutical Services

Regulations to provide essential services and implement an acceptable system of clinical governance.

Appendix 1 Southwest Devon Formulary and Referral (SWDFR)
Appendix 2 Smoking Cessation Guidelines
Appendix 3 Medication Protocol for Pharmacy PHS
Appendix 4 Pharmacy PHS Letter of Recommendation for Varenicline
Appendix 5 Which medicines need dose adjustment when a patient stops smoking?

10. CONTRACT MANAGEMENT

Contract Monitoring and Management Arrangements

All smoking cessation activity delivered under this PHS should be registered appropriately on PharmOutcomes.

Review meetings will be arranged by mutual agreement between the provider and the commissioner as required.

Consenting clients may be asked to complete a customer satisfaction survey as coordinated by Livewell South West Well Being Team

Delivery Location

As set out in original contract and subsequent variations to that contract.

APPENDICES

Appendix 1 Livewell South West Well Being Team

Appendix 2 Medication Protocol for Pharmacy PHS

Appendix 3 **Specialist Pharmacy Service interactions Q and A**

Appendix 1 Livewell South West Well Being Team

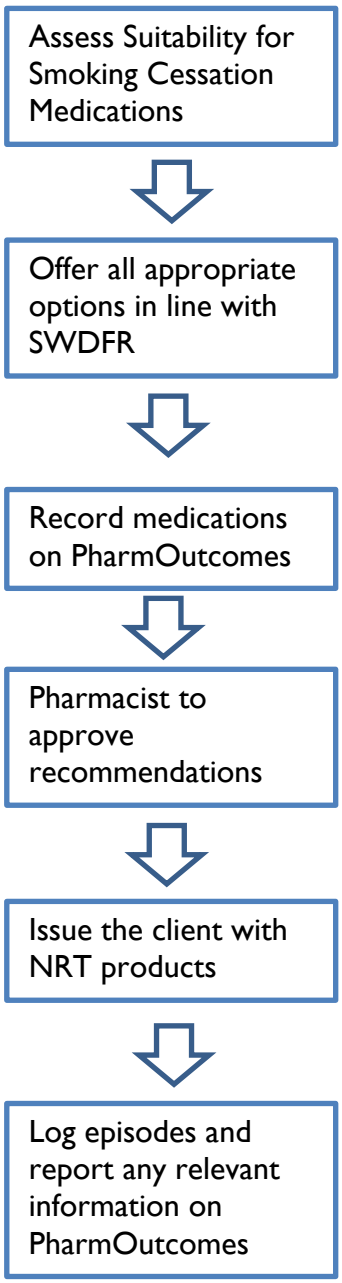
Contact details:

Livewell Southwest Wellbeing Team
Mount Gould Admin Block
200 Mount Gould Road
Plymouth
PL4 7QD
Telephone 01752 437177
Email: oneyou.plymouth@nhs.net
Website www.oneyouplymouth.co.uk

The Livewell Southwest Wellbeing Team offers a wide range of support to Community Practitioners/patients including:

- Provision of specialist clinic and groups across the city
- Provision of specialist support for pregnant women & their families
- Provision of specialist services in Well Being hubs across the city
- Provision of NCSCT standard training - workshop plus a whole range of training to support people to quit with differing needs.
- Provision of an annual conference to update skills and raise awareness of smoking related issues
- Provisions of in-practice brief intervention training, plus additional seminars
- Provision of CO monitors, materials and resources
- Data collection and feedback to practices
- Pharmacy visits to support practitioners
- Telephone support to practitioners

Appendix 2 Medication Protocol for Pharmacy PHS



Appendix 3

Specialist Pharmacy Service interactions Q and A

What are the clinically significant drug interactions with tobacco smoking?

Prepared by a UK Medicines Information (UKMi) team for NHS healthcare professionals. Before using this Q&A, read the disclaimer at https://www.sps.nhs.uk/articles/about-ukmi-medicines-qas/

Date prepared: July 2020

Summary

This Medicines Q&A summarises those drug interactions with tobacco smoking that are considered to be most clinically important.

Most interactions between drugs and tobacco smoking are not clinically significant. When giving smoking cessation advice, be aware of a small number of drugs, in particular aminophylline, theophylline, clozapine, erlotinib, olanzapine and riociguat, which may require dose adjustment or increased monitoring when smoking status is altered.

Close monitoring of plasma levels (where useful), clinical progress and adverse effect occurrence and severity is essential when patients change their smoking status.

Patients taking narrow-therapeutic-index drugs should be monitored closely when any lifestyle modification is made.

If the affected drug is prescribed under the supervision of a specialist, their input should be sought if the patient changes their smoking status.

Background

There are multiple constituents to tobacco smoke that may have the potential to induce hepatic cytochrome P450 (CYP) isoenzymes and other metabolic processes (1,2). Polycyclic aromatic hydrocarbons (PAHs) are a product of incomplete tobacco combustion and an inducer of hepatic enzymes as well being one of the major lung carcinogens found in tobacco smoke (1,2). Other compounds such as acetone, pyridine, heavy metals, benzene and carbon monoxide may also interact with hepatic enzymes, but their effects appear to be less significant (1). At present there are data that suggest PAHs induce CYP1A1, 1A2, 1B1, 2B6 and 2E1 as well as uridine diphosphate (UGT)-related metabolism (1-3). Tobacco smoke also appears to inhibit CYP2A6 (2). Of the tobacco-induced isoenzymes, CYP1A2 is the most clinically significant as many drugs are substrates for CYP1A2 (1,4). This Medicines Q&A summarises those drug interactions with tobacco smoking that are considered to be most clinically important.

Answer

Most interactions between drugs and tobacco smoking are not clinically significant.

If a patient starts to smoke and is taking a drug which is a substrate for an induced enzyme then increased metabolism can lead to a clinically significant reduction in pharmacologic effect and the dose may need to be increased (1,4). Conversely, if a

patient stops smoking then dose reduction needs to be considered due to downregulation of the enzyme-reducing drug metabolism which could lead to an increase in toxicity (1,4). Even if the degree of induction is weak it can still produce clinically significant events for drugs with a narrow therapeutic index (4).

Any dose adjustments need to be individually tailored. Patients can have different distributions of CYP enzymes, and the amount and type of tobacco smoked along with the degree of smoke inhalation can all vary the degree of enzyme induction (4,5). Close monitoring of plasma levels (where useful), clinical progress and adverse effect occurrence and severity is essential (4). Patients taking narrow-therapeutic-index drugs should be monitored closely when any lifestyle modification is made.

Drug interactions with tobacco smoking considered to be of most clinical importance are listed in the table below. The table describes the nature of the interaction and advises on appropriate management when a patient taking an interacting drug alters their smoking status. **If the affected drug is prescribed under the supervision of a specialist, their input should be sought if the patient changes their smoking status.**

Since most interactions are due to components of tobacco smoke and not due to nicotine, these interactions are not expected to occur with nicotine replacement therapy or e-cigarettes (vapes).

The following criteria have been considered in grading clinical relevance of drug interactions:

High: Documented pharmacokinetic interaction with clinically important effects in a number of patients.

Moderate: Documented pharmacokinetic interaction with minor clinical effects, or isolated reports of clinically important effects.

Note: For those wishing to assess the likelihood of interactions between tobacco smoking and drugs launched after this Medicines Q&A was prepared, a useful source for identifying the enzymes involved in a drug's metabolism is its Summary of Product Characteristics (SPC). Specifically, section 4.5 – interaction with other medicinal products and other forms of interaction, and section 5.2 – pharmacokinetic properties. Section 4.8 – undesirable effects, will list a drug's known adverse effects and their frequency.

Table. Clinically significant drug interactions with tobacco smoking.

Drug name	Nature of interaction	Clinical relevance	Action
Aminophylline Theophylline	Theophylline and aminophylline are metabolised in the liver by CYP1A2, 2E1 and 3A3 (6,7). Smoking can increase clearance of theophylline and aminophylline (6-8). Heavy smokers (20-40 cigarettes per day) may need much higher doses of than non-smokers (7). Full normalisation of hepatic function appears to take many months or even years after stopping aminophylline or theophylline (7).	**High** (narrow therapeutic index drug)	When stopping smoking, a reduction in theophylline dose of up to 25-33% might be needed after one week (7). If a patient starts to smoke, their dose may need to be increased as smokers often need higher maintenance doses (6).
Clozapine	Clozapine is almost completely metabolised before excretion by CYP1A2 and 3A4, and to some extent by 2C19 and 2D6 (6,9). Smokers may need higher doses due to increased clearance of clozapine (7,9). There have been case reports of adverse effects in patients who abruptly stopped smoking (6,7,9).	**High**	Take clozapine plasma level before stopping smoking. On stopping, reduce dose gradually (over 1 week) until around 75% of original dose reached (i.e. reduce by 25%). Repeat plasma level 1 week after stopping. Anticipate further dose reductions (4). If a patient has stopped smoking and intends to re-start, take their clozapine plasma level before they do so. Increase dose to previous smoking dose over 1 week. Repeat plasma level (4). If a patient starts smoking it has been suggested a 50% increase in clozapine dose should be anticipated (7).
Erlotinib	Erlotinib is metabolised primarily by CYP3A4 and to a lesser extent by	**High**	Current smokers should be advised to stop smoking as early as

Drug name	Nature of interaction	Clinical relevance	Action
	1A2 (6,10). Cigarette smoking has been shown to reduce erlotinib exposure by 50-60% (10). Smokers gain less benefit than non-smokers from erlotinib in clinical studies (7).		possible before initiation of treatment (10). If the patient stops smoking the erlotinib dose should be immediately reduced to the indicated starting dose (6). When given to patients who smoke, increase the daily dose of erlotinib in 50mg increments at 2-week intervals, up to a maximum daily dose of 300mg, the licensed maximum dose in smokers (6).
Olanzapine	Olanzapine is metabolised by glucuronidation and CYP1A2, both of which are induced by smoking, leading to increased clearance of olanzapine (6,7,11). To a lesser extent olanzapine is also metabolised by CYP2D6 (6). Smokers have lower olanzapine serum levels and require higher daily doses compared to non-smokers (7). There are case reports of extrapyramidal symptoms developing when a patient stops smoking (7).	High	On stopping smoking reduce dose by 25% (4). Closely monitor patient and consider further dose reductions if necessary, according to patient response (4,7). If restarting smoking, increase dose to previous smoking dose over 1 week (4). Monitor the patient closely making further dose adjustments as needed, dependent upon patient response (4,7,11). If a patient starts smoking monitor them closely and increase dose if required, adjusted to patient response (7,11). If olanzapine plasma level monitoring is available, it may help to take levels before stopping/starting smoking and repeat them one week after the dose change (4).
Riociguat	Riociguat is mainly metabolised by CYP1A1, 2C8, 2J2, 3A4 and 3A5 (6,12). Plasma concentrations of riociguat are reduced by 50-60% in smokers compared to non-smokers (6,12).	High	Current smokers should be advised to stop smoking (7,12). A dose decrease may be required in patients who stop smoking (6,7,12). A dose increase to the maximum daily dose of 2.5mg three times daily may be required in patients who are smoking or start smoking during treatment (6,7,12).
Chlorpromazine	Chlorpromazine is extensively metabolised in the liver (13). Studies indicate clearance of chlorpromazine may be increased in patients who smoke (6). A comparative study found smokers	Moderate	When stopping smoking, monitor patient closely and consider dose reduction (4,7). If re-starting smoking, monitor patient closely and consider re-starting previous smoking dose

Drug name	Nature of interaction	Clinical relevance	Action
	experienced a lower frequency of drowsiness than non-smokers (7). A case report describes a patient experiencing increased sedation and dizziness when they gave up smoking (7).		(4,7).
Flecainide	*In vitro* studies have shown CYP1A2 to be involved in the metabolism of flecainide (7). CYP2D6 also appears to be involved (6,14). The clearance of flecainide was found to be 50% higher in smokers than in non-smokers (7). Smokers are likely to require larger doses of flecainide than non-smokers to achieve the same therapeutic effects (7).	Moderate	If a patient abruptly stops smoking be alert for flecainide adverse effects and be aware that it is likely that the dose of flecainide will need to be reduced (7).
Methadone	Methadone is metabolised in the liver by numerous enzymes including CYP1A2, 2B6 and 3A4 (6,7,15,16). One case report of respiratory insufficiency and altered mental status was reported in a patient taking methadone as an analgesic who stopped smoking (7).	Moderate	If a patient, who takes methadone, stops smoking they should be monitored for signs of methadone toxicity. The dose of methadone should be adjusted accordingly (16).
Warfarin	Warfarin is partly metabolised by CYP1A2 and 2C9 (6,7). A systematic review and meta-analysis concluded that smoking can increase warfarin clearance, leading to reduced warfarin effects and smokers requiring slightly higher doses (6).	Moderate (narrow therapeutic index drug)	Monitoring of smoking status during warfarin therapy is advised (6,17). Routine INR monitoring should detect any need for dose adjustments (7). Be alert for the need to alter warfarin doses in patients who have changed their smoking status (7,17,18).

Summary

- Most interactions between drugs and tobacco smoking are not clinically significant.
- When giving smoking cessation advice, be aware of a small number of drugs, in particular aminophylline, theophylline, clozapine, erlotinib, olanzapine and riociguat, which may require dose adjustment or increased monitoring when smoking status is altered.
- Close monitoring of plasma levels (where useful), clinical progress and adverse effect occurrence and severity is essential when patients change their smoking status.
- Patients taking narrow-therapeutic-index drugs should be monitored closely when any lifestyle modification is made.
- If the affected drug is prescribed under the supervision of a specialist, their input should be sought if the patient changes their smoking status.

Limitations

- This Q&A does not include drugs which have a low risk, theoretical interaction without documented cases and/or drugs metabolised partly by induced CYP enzymes with a wide therapeutic range.
- It does not consider interactions with pharmacological agents used for smoking cessation (e.g. bupropion, varenicline), or pharmacodynamics interactions (e.g. effects of smoking on blood pressure). It does not include potential interactions of nicotine replacement therapy, using ecigarettes (vapes) or chewing tobacco.

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Quality Assurance

Prepared by Gary Hodgson. Medicines Information Pharmacist. North West Medicines Information Centre, 70 Pembroke Place, Liverpool, L69 3GF

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Checked by Emily Westwood (Medicines Information Pharmacist), Helen Edmondson (Medicines Information Technician) and Joanne McEntee (Senior Medicines Information Pharmacist). North West Medicines Information Centre, 70 Pembroke Place, Liverpool, L69 3GF Date of check July/August 2020

Contact nwmedinfo@nhs.net

Appendix 4 Glossary of terms

COPD
Chronic Obstructive Pulmonary Disease

CO-verified four-week quitter
A treated smoker who reports not smoking for at least days 15–28 of a quit attempt and whose Carbon monoxide (CO) reading is assessed 28 days from their quit date (-3 or +14 days) and is less than 10 ppm. The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell Standard).

CO verification should be conducted face to face and carried out in at least 85% of self-reported four week quitters.

Commissioner
Plymouth City Council

CVD
Cardiovascular Disease

DH
Department of Health

CPPE
Centre for Pharmacy Postgraduate Education

HIP
Health Improvement Practitioner

HLP
Healthy Living Pharmacy

LoR
Letter of Recommendation (for Varenicline)

Lost to follow-up (LTFU)
A treated smoker who cannot be contacted face to face, via telephone, email, letter or text following three attempts to contact them at different times of day, at four weeks from their quit date (or within 25 to 42 days of the quit date). The four-week outcome for this client is unknown and should therefore be recorded as LTFU on the monitoring form.

NRT
Nicotine Replacement Therapy

PCC
Plymouth City Council (Commissioner)

PHS
Public Health Service

Practitioner
Stop Smoking Practitioner, employed by the Provider Lead named above

Stop smoking service provider
A stop smoking service provider is defined as a locally managed and coordinated service commissioned to provide accessible, evidence-based and cost-effective clinical services to support smokers who want to stop.
Service delivery should be in accordance with the quality principles for clinical and financial management contained within this guidance.

NCSCT
National Centre for Smoking Cessation Training

Non-treated smoker
A smoker who receives no support or is given very brief advice and/or supplied with leaflets, helpline cards or pharmacotherapy only, and who does not set a quit date or consent to treatment. Examples may include smokers seen at health fairs or community events, during a GP consultation or during a hospital stay where a quit date is not set and a quit attempt is not made.

LSWWBT
Livewell South West Well Being Team

LoR
Letter of Recommendation (for Varenicline)

ODPH
Office of the Director of Public Health

Provider
Community Pharmacy providing Stop Smoking Service to clients

Quit date
The date a smoker plans to stop smoking completely with support from a stop smoking practitioner as part of an assisted quit attempt.

Renewed quit attempts
A quit attempt that takes place immediately following the end of one treatment episode.
A new treatment episode should be commenced in the database / service records.

Routine and manual smoker
A smoker whose self-reported occupational grouping is of a routine and manual (R/M) worker as defined by the National Statistics Socio-Economic Classification.137

Self-reported four-week quitter
A treated smoker who reports not smoking for at least days 15–28 of a quit attempt and is followed up 28 days from their quit date (-3 or +14 days). The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell Standard).

Smoked product
Any product that contains tobacco and produces smoke is a smoked product, including cigarettes (hand-rolled or tailor-made), cigars and pipes (including waterpipes). Waterpipes include shisha, hookah, narghile and hubble-bubble pipes.

Smoker
A person who smokes a smoked product. In adulthood this is defined in terms of daily use, whereas in adolescence (i.e. for those aged 16 or under) it is defined in terms of weekly use.

Smoking cessation
In clinical terminology this is used to denote activities relating to supporting smokers to stop.

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Spontaneous quitters
Smokers who have already stopped smoking when they first come to the attention of the service can only be counted as having been 'treated' and included in the national data return if they had quit 48 hours or less before attending the first session of a structured multi-session treatment plan. Where this is the case, their spontaneous quit date should be recorded as their actual quit date. Examples of such quitters include clients who experience unplanned admission to hospital and stop smoking before receiving support, those people who have started using nicotine vapourisers (as an alternative to smoking) and have not smoked for up to 48 hours, or pregnant smokers who have already stopped smoking before approaching their local stop smoking service provider. Whilst it is recognised that it is desirable to offer as many smokers as possible support to quit and maintain abstinence, local commissioners will need to balance the needs of their smoking population against available service resources. Smokers who have already stopped smoking for more than 48 hours before attending a service should not be included in the national data submission but may be counted as having been 'treated' for local accounting purposes (e.g. to justify resources used or analyse performance). It is recommended that this is only recorded if they have quit within 14 days prior to coming to the attention of the service and have attended the first session of a structured multisession treatment plan within 14 days of their spontaneous quit date (which should be recorded as their quit date).

Stop smoking
Preferred term to denote patient-facing communications relating to smoking cessation activity.

Stop smoking practitioner
An individual who has NCSCT certification and is employed by a service which is, either directly or indirectly, commissioned to provide stop smoking support.

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Time between treatment episodes
(see Treatment episode, below)
When a client has not managed to stop smoking, there is no definitive period of time required between the end of a treatment episode and the start of another. The stop smoking practitioner should use discretion and professional judgement when considering whether a client is ready to receive support to immediately attempt to stop again. If this is the case, the client must start a new treatment episode, i.e. attend one session of a structured, multi-session intervention, consent to treatment and set a quit date with a stop smoking practitioner in order to be counted as a new data entry on the quarterly return.

Treated smoker
A smoker who has received at least one session of a structured, multi-session intervention (delivered by a stop smoking practitioner) on or prior to the quit date, who consents to treatment and sets a quit date with a stop smoking practitioner. Smokers who attend a first session but do not consent to treatment or set a quit date should not be counted.

Treatment episode
At the point of attending one session of a structured, multi-session intervention, consenting to treatment and setting a quit date with a stop smoking practitioner, a client becomes a treated smoker and the treatment episode begins. The treatment episode ends when a client has been completely abstinent for at least the two weeks prior to the four-week follow-up or is lost to follow-up at the four-week point, or when a four-week follow-up reveals that a client has lapsed during the two weeks immediately prior to the follow-up and is therefore recorded as a non-quitter. Good practice dictates that if the client wishes to continue treatment after a lapse, treatment should be continued if it seems appropriate, but the client will not count as a four-week quitter for the purposes of that treatment episode.